

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**  
**Docket Number: M-11-1350**

**In the case of**

**Claim for**

J.A.C.

Medicare Advantage (MA)  
Benefits (Part C)

\_\_\_\_\_  
(Appellant)

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\_\_\_\_\_  
(Enrollee/Beneficiary)

\_\_\_\_\_  
(HIC Number)

Highmark Blue Shield/  
FreedomBlue PPO

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\_\_\_\_\_  
(MA Organization (MAO)/  
MA Plan)

\_\_\_\_\_  
(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision on April 6, 2010. The ALJ determined that the enrollee did not require skilled nursing or skilled rehabilitation services on a daily basis after December 25, 2009, and, accordingly, upheld the Quality Improvement Organization's (QIO's) determination that the termination of skilled nursing facility (SNF) coverage beginning December 26, 2009, was appropriate. The ALJ concluded that the MA plan may not be required to cover the charges incurred for the enrollee's SNF stay on and after December 26, 2009. The appellant/enrollee (represented by her son) has asked the Medicare Appeals Council (Council) to review the ALJ's decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC [Medicare Appeals Council] review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeal procedures found at 42 C.F.R. part 405, subpart I. With respect to Medicare "fee-for-service" appeals, the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 70 Fed. Reg. 11420, 11421-11426 (March 8, 2005). The Council has determined,

until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), that it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I, to this case.<sup>1</sup>

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. See 42 C.F.R. § 405.1112(c).

The Council admits the following documents into the administrative record, identified by Exhibit (Exh.) number:

Request for Review, received 06/11/2010	Exh. MAC-1
Correspondence from Council 06/22/2010	Exh. MAC-2
Correspondence from appellant, 07/07/2010	Exh. MAC-3
Correspondence from appellant, 11/03/2010	Exh. MAC-4
Council's Remand Order, 11/17/2010	Exh. MAC-5
Council's Remand Order, 02/03/2011	Exh. MAC-6
ALJ's Order of Removal, 04/11/2011	Exh. MAC-7
Correspondence from appellant, 07/11/2011	Exh. MAC-8
Correspondence from appellant, 04/05/2012	Exh. MAC-9
Correspondence from Council, 04/09/2012	Exh. MAC-10
Correspondence from appellant, 04/09/2012	Exh. MAC-11

The Council received the appellant's request for review on June 11, 2010, and docketed it as M-10-1386. Exh. MAC-1. The Council was unable to retrieve the record from the Centers for Medicare & Medicaid Services (CMS), or any other source, despite repeated efforts. Exh. MAC-5. Therefore, on November 17, 2010, the Council remanded the case to the ALJ to reconstruct the record or develop a new record. *Id.* The Council stated that it would vacate its Order if the complete record, including the audio recording of the ALJ hearing, was located and made available to the Council. *Id.* On December 7, 2010, the Council received documents that pertain to the claim at issue. See Exh. MAC-6. The case was re-docketed as M-11-448. However, the Council's review of the record revealed that neither the ALJ's numbered exhibits nor a signed copy of the ALJ's decision were among the documents that purported to be the claim file. *Id.*

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<sup>1</sup> As noted by CMS, "the provisions that are dependent upon qualified independent contractors would not apply since an independent review entity [IRE] conducts reconsiderations for MA appeals." 70 Fed. Reg. 4676 (Jan. 28, 2005).

Therefore, on February 3, 2011, the Council again remanded the case to an ALJ to reconstruct the file. *Id.* By order dated April 11, 2011, the ALJ returned the file to the Council. Exh. MAC-7. As the file now appears to be complete, the Council vacates its November 17, 2010, and February 3, 2011 remand orders in M-10-1386 and M-11-448, respectively, and addresses the appellant's request for review.

The Council finds no basis for altering the ALJ's decision and, accordingly, adopts the ALJ's decision.

### DISCUSSION

The ALJ's decision provides a recitation of facts and legal authorities. Dec. at 2-11. The Council incorporates that discussion by reference and will not repeat it in full in this action.

Briefly, the enrollee, 68 years old during the time period at issue, was hospitalized on November 18, 2009, for low back pain and urinary tract infection. Exh. 6, at 124-25. Her past medical history included bipolar disorder, depression, diet-controlled diabetes, hypercholesterolemia, and hypertension. *Id.* at 125. The enrollee was admitted to \*\*\* Health Center (\*\*\* or provider), a SNF, on November 20, 2009. See *id.* at 123. At \*\*\*, the enrollee received skilled physical therapy (PT) and occupational therapy (OT) from November 22, 2009, to December 24, 2009. See *id.* at 67-102. The enrollee was discharged from \*\*\* on December 28, 2009, at which time she returned home. See *id.* at 114, 107.

On December 23, 2009, the provider notified the enrollee that Medicare coverage for her SNF stay would end on December 25, 2009. Exh. 2, at 45-46. Also on December 23, 2009, the enrollee's representative made a telephone request for an expedited determination to challenge the decision to end coverage of SNF services. See Exh. 4, at 56. On December 24, 2009, the MA plan issued a "Detailed Explanation of Non-Coverage" in which it stated that the enrollee had met or surpassed her goals in OT and PT; accordingly, she no longer required skilled services. Exh. 2, at 47-52. On December 25, 2009, Quality Insights of Pennsylvania, the QIO, issued an expedited determination concluding that the plan's decision to end coverage was correct. Exh. 4, at 58-60. On December 29, 2009, the QIO issued a reconsideration upholding the termination of coverage. Exh. 5.

The enrollee requested a hearing before an ALJ. Exh. 6, at 137-39. The ALJ held a hearing, by telephone, on April 1, 2010. Dec. at 2. The enrollee's representative appeared before the ALJ and presented testimony and argument. In the hearing decision, issued April 6, 2010, the ALJ agreed with the QIO that termination of SNF care was appropriate as of December 25, 2009, because skilled PT and OT were no longer medically reasonable and necessary for the enrollee. *Id.* at 11-12.

Before the ALJ, the enrollee argued that she could not leave the SNF before the attending physician examined her and signed discharge orders. See Exh. 6, at 138. She further argued that, as a practical matter, because of the Christmas holiday, the first opportunity for the physician to examine her was Monday, December 28, 2009. *Id.* She therefore argued that she should not be financially responsible for the three days of non-covered SNF charges incurred from December 26 to 28, 2009. *Id.* The ALJ concluded that this was not a basis for finding that the care on those dates qualified for Medicare coverage. Dec. at 12. Before the Council, the enrollee argues that the provider's medical records demonstrate that the enrollee's medical condition was such that she continued to need skilled observation and assessment by nursing staff, as well as skilled rehabilitation services, on and after December 26, 2009. See Exh. MAC-1. The ALJ addressed these arguments as well, finding that the enrollee did not require or receive skilled services. Dec. at 11-12. The Council finds no error in the ALJ's conclusions.<sup>2</sup>

To qualify for Medicare coverage, SNF care must meet four basic criteria, as outlined in the Medicare Benefit Policy Manual (MBPM), CMS Internet Only Manual (IOM) 100-02:

- The patient requires skilled nursing services or skilled rehabilitation services;
- The patient requires such services on a daily basis;
- As a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF; and
- The services are reasonable and necessary for the treatment of a patient's illness or injury, as well as reasonable in terms of duration and quantity.

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<sup>2</sup> Among the enrollee's objections to the ALJ's decision is that it was based on incomplete medical records. Exh. MAC-1, at 3-4. However, all the documents referenced by the enrollee were included in her submissions to the ALJ (Exh. 6) and, as such, were a part of the record before him. Moreover, in this decision the Council considers the enrollee's arguments based on these documents and concludes that the ALJ did not err.

MBPM, Ch. 8, § 30.<sup>3</sup> That the enrollee may have benefited from further therapy or, more generally, from having her care overseen by SNF personnel rather than being discharged home, is not determinative for continuing SNF level of care. The enrollee must need *and receive* skilled nursing or rehabilitative therapy on a *daily* basis *which cannot reasonably be provided in a less intensive care setting*. 42 C.F.R. § 409.31(b) (emphasis added). Moreover, for rehabilitative therapy furnished in a SNF setting to be considered reasonable and necessary, the therapy must be, among other things, reasonable in terms of the amount, frequency, and duration. See, e.g., MBPM, Ch. 8, Section 30.4.1.1.

The Council has carefully considered the record and concurs with the ALJ's assessment of the evidence. First of all, the record does not indicate that the beneficiary required, or received, *daily* skilled nursing care, either before or after the last covered date, December 25, 2009. The enrollee argues that skilled nursing on a daily basis was required to observe, assess, and/or treat the cellulitis that affected both lower extremities. See Exh. MAC-1, at 9. The evidence does not support a conclusion that skilled nursing was required or received on a daily basis for this condition.

The enrollee was diagnosed with cellulitis on December 15, 2009. See Exh. 6, at 123. Her treating physician prescribed oral antibiotics and an oral diuretic to treat the condition. *Id.* Administration of oral medications does not require skilled nursing care. The nursing notes document that, after the beneficiary was diagnosed with cellulitis, there was only one occasion on which the nursing staff reported symptoms to the physician, and no new orders were given. *Id.* at 108 (12/16 22:10 "Lower extremities edematous and red. Note left for Dr"). Thus, from December 15, 2009, when she was diagnosed, until the last covered day December 25, 2009, the enrollee continued on oral antibiotics, and was not receiving other skilled nursing interventions. *Id.* at 107-108. On December 25, 2009, the nursing staff documented that the enrollee was experiencing less edema, and no discomfort, although her legs were still reddened. *Id.* at 108. From December 26-28, 2009, the nursing notes do not document any observations of the enrollee's cellulitis symptoms. *Id.* at 107. Also, the attending physician signed an order for ICF (intermediate care facility) level of care effective December 26, 2009, which is not a Medicare covered skilled level

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<sup>3</sup> Manuals issued by CMS can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.

of care. Exh. 15 at 220. Thus, contrary to the enrollee's assertion that she was experiencing a potentially life-threatening condition (see, e.g., Exh. MAC-1, at 9) that required intensive daily skilled nursing care, the picture that emerges from the documentation is of a condition that was responding as expected to oral medications.

Second, the enrollee argues that she continued to be in need of skilled rehabilitation services on and after the last covered day. See, e.g., Exh. MAC-1, at 4-5. In support of this contention, she points to PT and OT recertifications completed on December 23, 2009. See Exh. 6, at 70-73, 89-91, 115. In these documents, the therapists requested physician recertification of the need for PT for the period 12/22/2009-1/20/2010 and for OT for the period 12/23/2009-1/21/2010.<sup>4</sup> *Id.* However, as noted above, to be covered by Medicare skilled therapy must be reasonable in amount and duration. As of the last covered day, the enrollee had been receiving daily skilled therapy for five weeks and had achieved most of her functional goals.<sup>5</sup> Accordingly, the ALJ did not err in concluding that continuation of skilled level of care was not reasonable or necessary after that date.

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<sup>4</sup> The Council notes that the enrollee's initial plans of treatment called for four weeks of therapy for each discipline. See, e.g., Exh. 6, at 85, 102. Thus, recertification was required in order for the beneficiary to receive covered treatment on 12/23/2009 and 12/24/2009.

<sup>5</sup> Six goals were established for the enrollee's PT. See, e.g., Exh. 6, at 87. The enrollee last received PT on December 24, 2009. *Id.* at 88. As of her discharge on December 28, 2009, the physical therapist documented that the enrollee fully met three of her goals, exceeded one, and substantially met the remaining two (e.g., the goals were met with the use of adaptive equipment). *Id.* at 87. Moreover, the physical therapist documented that the enrollee had achieved her highest practical level of function. *Id.* Similarly, of the twelve goals set for the enrollee in OT, ten were met and two were substantially met on or before December 23, 2009. See *id.* at 67-69.

The Council notes that the enrollee submitted an affidavit executed by the attending physician in which he opines that the enrollee should have continued to receive skilled nursing and skilled rehabilitation services after the last covered day. Exh. MAC 3. Even if the Council were to credit the attending physician's opinion that the beneficiary would have benefited from skilled care after December 25, 2009, the affidavit does not establish that the beneficiary in fact received daily skilled services. In this regard, we note, in addition to the order for an ICF level of care effective December 26, 2009, noted *supra*, that the physician's affidavit only states that she required "practically daily" therapy. Exh. MAC-5. The physician also wrote that the beneficiary was well enough to leave the SNF on December 28, 2009, without immediate danger to her health. Moreover, no special weight is given to the opinion of the treating physician, as provided in CMS Ruling 93-1. By regulation, CMS Rulings are binding on the Council. 42 C.F.R. §§ 401.108, 405.1063. Therefore, the opinion of the attending physician is not a basis for changing the ALJ's decision.

In addition to finding that the MA plan properly ended Medicare coverage for the enrollee's SNF services as of December 25, 2009, the ALJ also found that the enrollee remains responsible for the non-covered SNF charges on and after December 26, 2009, based on her receipt of a valid advance written notice of the proposed discharge and termination of coverage. Dec. at 12. The enrollee has not raised any exceptions to the ALJ's finding that she is responsible for the non-covered charges. The Council therefore will not disturb this portion of the ALJ's decision.

Finally, the appellant's claim for expenses for subsequent outpatient treatment after SNF discharge is not cognizable in this appeal. The issues before the ALJ that were brought out in the appeal levels below concerned only coverage for the continued stay at the SNF through December 28, 2009, for which the appellant was charged two days of room and board at \$224 per day.<sup>6</sup> 42 C.F.R. § 405.1032, Exh. 15 at 244. This is the only issue considered in the organization determination pursuant to 42 C.F.R. § 422.566, appealed through all levels, and properly before the Council. The appellant must present a claim directly to the MAO for the other expenses incurred on an outpatient basis through February 2010 for which recovery is sought as damages. Exh. MAC-1. See 42 C.F.R. § 405.1032(c) (An ALJ does not have jurisdiction over a claim, including one that is

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<sup>6</sup> The day of discharge is not counted.

related to an issue before an ALJ, unless it has been adjudicated at the lower appeals levels).

For the reasons explained above, the enrollee's exceptions are not a basis for changing the ALJ's decision. The Council therefore adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki  
Administrative Appeals Judge

Date: June 13, 2012